





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11222

## CERTIFICATE OF DEATH

Reg. Dist. No. 11203

|  |   |   |   |  |  |   |   |
|--|---|---|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert</b> MARYLAND   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>  |   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>                                |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Calvert County Hospital</b>   |   |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Frank</b> Middle <b>Gross</b> Last <b>Gross</b>  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>28</b> Year <b>1959</b> |  |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/12/94</b>                                      | 9. AGE (In years last birthday) yrs. <b>65</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.                    |   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY                                       |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |
| 13. FATHER'S NAME<br><b>unknown</b>  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca Gross</b>                        |  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>213-26-3554</b>   |   | 17. INFORMANT<br><b>Helen Gross Pa. Frederick, Md.</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension C.V.D.</b><br>DUE TO (c) |   |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                         |   |   |
| 21. I certify that I attended the deceased from <b>10-27, 1959</b> , to <b>10-28, 1959</b> , that I last saw the deceased alive on <b>10-28, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.  |   |   |   |  |  |   |   |
| ACTUAL SIGNATURE<br><b>R. E. Villareal</b>   |   |   | ADDRESS (Street, city or town, state)<br><b>St. Leonard</b>             |  |  | DATE SIGNED   |   |
| PHYSICIAN'S NAME (Type)<br><b>R. E. VILLAREAL MD</b>   |   |   |   |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF<br><b>10-31-59</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Prince Frederick, Md.</b>  |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>P. J. Sewell, Prince Frederick, Md.</b>   |   |   | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br><b>NOV 3 '59</b>                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thorne</b> |   |

2000

10-55 24 55-01

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11223

## CERTIFICATE OF DEATH

11204

Reg. Dist. No.

|  |  |   |  |  |  |  |                                  |
|--|--|---|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Cabaret</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Ind</u> b. COUNTY <u>Cabaret</u>                    |  |  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Prime Frederick</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>7 wks</u>  |  |  |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Cabaret Co. Hospital</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |                                  |
| 3. NAME OF DECEASED (Type or print) <u>G. Herbert</u> First <u>Hutchins</u> Middle <u>Hutchins</u> Last  |  |   |  | 4. DATE OF DEATH <u>Oct. 27</u> 19 <u>59</u>   |  |  |                                  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Sept. 4, 1884</u>  |                                  |
| 9. AGE (In years last birthday) <u>75</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farm Owner</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Cabaret Co. Ind</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                      |                                  |
| 13. FATHER'S NAME<br><u>Israel Hutchins 38-4913</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Sarah E. Robinson</u>   |  |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO. <u>24-4913</u>   |  |  |                                  |
| 17. INFORMANT<br><u>Edgar F. Hutchins - Prime Frederick, Ind.</u>  |  |   |  | Address  |  |  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Acute myocardial C.V.R. disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u><br>DUE TO (c) _____ |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |  |   |  |  |  |  |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)             |                                  |
| 20f. (City or town) _____ (County) _____ (State) _____   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |                                  |
| 21. I certify that I attended the deceased from <u>8-2</u> , 19 <u>59</u> , to <u>10-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-27</u> , 19 <u>59</u> , and that death occurred at <u>2:15</u> M. from the causes and on the date stated above.   |  |   |  |  |  |  |                                  |
| ACTUAL SIGNATURE <u>[Signature]</u>  |  |   |  | ADDRESS (Street, city or town, state) <u>Huntingtown, Ind.</u> DATE SIGNED <u>10/27/59</u>   |  |  |                                  |
| PHYSICIAN'S NAME (Type) <u>G. J. WEEMS</u>   |  |   |  | M.D. <u>HUNTINGTOWN, IND.</u>  |  |  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>Oct. 29, 1959</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Central Amities</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Benton - Cabaret Co - Ind.</u> |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>G. G. Harkness &amp; Son - Huntingtown, Ind.</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>NOV 2 '59</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>                               |                                  |

CERTIFICATE OF DEATH

11822

11804

Reg. Dist. No.

Place of Death

Residence

Place of Birth

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Usual Place of Abode

Usual Place of Work

Usual Place of Recreation

Usual Place of Travel

Usual Place of Residence

Usual Place of Employment

Usual Place of Education

Usual Place of Religion

Usual Place of Usual Place of Abode

Usual Place of Usual Place of Work

Usual Place of Usual Place of Recreation

Usual Place of Usual Place of Travel

Usual Place of Usual Place of Residence

Usual Place of Usual Place of Employment

Usual Place of Usual Place of Education

Usual Place of Usual Place of Religion

Usual Place of Usual Place of Usual Place of Abode

Usual Place of Usual Place of Usual Place of Work

Usual Place of Usual Place of Usual Place of Recreation

Usual Place of Usual Place of Usual Place of Travel

Usual Place of Usual Place of Usual Place of Residence



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11205

Reg. Dist. No.

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| <b>1. PLACE OF DEATH</b><br>o. COUNTY <i>Calvert</i><br>MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ches Beach</i><br>c. LENGTH OF STAY IN 1b  |                                     | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission)<br>a. STATE <i>MD</i><br>b. COUNTY <i>Calvert</i><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ches Beach MD</i><br>d. STREET ADDRESS <i>15th + Colorado Ave.</i><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <i>James</i> Middle <i>Arthur</i> Last <i>Hane</i>   |                                     | <b>4. DATE OF DEATH</b><br>Month <i>10</i> Day <i>13</i> Year <i>1959</i>  |   |
| <b>5. SEX</b><br><i>MO</i>   | <b>6. COLOR OR RACE</b><br><i>W</i> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><i>March 8, 1898</i>         |
| <b>9. AGE</b> (In years last birthday) <i>61</i> yrs.  |                                     | <b>IF UNDER 1 YEAR</b><br>Months <i>0</i> Days <i>0</i>  | <b>IF UNDER 24 HRS.</b><br>Hours <i>0</i> Min. <i>0</i> |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><i>Marine Corps</i>  |                                     | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><i>Summers</i>   |   |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><i>MD</i>  |                                     | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><i>USA</i>  |   |
| <b>13. FATHER'S NAME</b><br><i>James A Kane</i>  |                                     | <b>14. MOTHER'S M maiden name</b><br><i>Catharine Sharp</i>  |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)<br><i>No 1917-1947</i>  |                                     | <b>16. SOCIAL SECURITY NO.</b><br><i>—</i>   |   |
| <b>17. INFORMANT</b><br><i>Wm J Kane</i>   |                                     | <b>Address</b><br><i>Ches. Beach</i>   |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <i>Cardiac failure</i><br>782.4 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>782.4</i><br>DUE TO (c) |                                     |  |   |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><i>Found dead in bed</i>   |                                     |  |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     | <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>   |   |
| <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)<br><i>Found dead in bed</i>   |                                     | <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <i>9</i> o. m. <i>10/13</i> 19 <i>59</i>   |   |
| <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |                                     | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>Home</i>  |   |
| <b>20f. (City or town)</b> <i>Ches Beach</i>   |                                     | <b>(County)</b> <i>Calvert</i>   |   |
| <b>(State)</b> <i>MD</i>   |                                     | <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |   |
| <b>ACTUAL SIGNATURE</b><br><i>H. W. Ward</i>   |                                     | <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>  |   |
| <b>EXAMINER'S NAME (Type)</b><br><i>H. W. WARD</i>   |                                     | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>   |   |
| <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>   |                                     | <b>DATE SIGNED</b><br><i>10/15/59</i>  |   |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><i>Burial</i>  |                                     | <b>22b. DATE THEREOF</b><br><i>10-16-59</i>  |   |
| <b>22c. NAME OF CEMETERY OR CREMATOR</b><br><i>Arlington National</i>  |                                     | <b>22d. LOCATION (City, town, or county)</b><br><i>Pa.</i>   |   |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><i>Kutchen Funeral Home (Pocahontas)</i>  |                                     | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE</b> <i>OCT 16 '59</i>  |   |
| <b>ADDRESS</b><br><i>Kutchen Funeral Home (Pocahontas)</i>   |                                     | <b>24b. REGISTRAR'S SIGNATURE</b><br><i>Arthur S. Kraus</i>  |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|  |  |  |  |
|--|--|--|--|
| NAME OF DECEASED<br>_____<br>SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |  | DATE OF DEATH<br>_____                 |  |
| PLACE OF DEATH<br>_____  |  | TIME OF DEATH<br>_____                 |  |
| NAME OF PHYSICIAN<br>_____   |  | NAME OF MEDICAL EXAMINER<br>_____      |  |
| ADDRESS OF DECEASED<br>_____   |  | ADDRESS OF PHYSICIAN<br>_____          |  |
| OCCUPATION OF DECEASED<br>_____  |  | OCCUPATION OF PHYSICIAN<br>_____       |  |
| CAUSE OF DEATH<br>_____  |  | MANNER OF DEATH<br>_____               |  |
| MEDICAL HISTORY<br>_____   |  | SOCIAL HISTORY<br>_____                |  |
| PHYSICAL EXAMINATION<br>_____  |  | LABORATORY EXAMINATIONS<br>_____       |  |
| POST-MORTEM EXAMINATION<br>_____   |  | OTHER INFORMATION<br>_____             |  |
| SIGNATURE OF PHYSICIAN<br>_____  |  | SIGNATURE OF MEDICAL EXAMINER<br>_____ |  |
| DATE OF SIGNATURE<br>_____   |  | DATE OF SIGNATURE<br>_____             |  |

RECEIVED  
 DEPARTMENT OF HEALTH  
 BALTIMORE, MARYLAND  
 JAN 15 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11206

11225

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <i>Calvert</i> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>md</i> b. COUNTY <i>Harrett</i> ✓                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Prince Frederick</i>  | c. LENGTH OF STAY IN 1b<br><i>3 days</i>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Granterville 11X-2</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Calvert County Hospital</i>   |  | d. STREET ADDRESS<br>—  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Virginia</i> Middle <i>E.</i> Last <i>Miller</i>   |  | 4. DATE OF DEATH<br>Month <i>Oct.</i> Day <i>4</i> Year <i>1959</i>   |   |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>W</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Feb. 24, 1878</i>  |
| 9. AGE (In years last birthday)<br><i>81</i> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>  | 11. BIRTHPLACE (State or foreign country)<br><i>Hager, Md</i>                                     |
| 13. FATHER'S NAME<br><i>George Bischoff</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Martha Sisler</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>  |  | 16. SOCIAL SECURITY NO.<br><i>No</i>  |   |
| 17. INFORMANT<br><i>Mrs Aberta Williams - St. Leonard, Md.</i>   |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Heart Failure</i><br>434.4 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive heart - Generalized arteriosclerosis</i><br>DUE TO (c) <i>arteriosclerosis</i> |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <i>19</i>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <i>OCT 2</i> , 19 <i>59</i> , to <i>OCT 4</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>OCT 4</i> , 19 <i>59</i> , and that death occurred at <i>6:17</i> M, from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE<br><i>Rosewellan</i>  |  | ADDRESS (Street, city or town, state) <i>St Leonard</i> DATE SIGNED <i>10/4/59</i>  |   |
| PHYSICIAN'S NAME (Type)<br><i>R DE VILLARREAL MD</i>   |  | <i>Calvert MARYLAND</i>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 22b. DATE THEREOF<br><i>Oct 6, 1959</i>  | 22c. NAME OF CEMETERY OR CREMATORY<br><i>Granterville Cem.</i>  | 22d. LOCATION (City, town, or county) (State)<br><i>Granterville Md.</i>                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Newman Funeral Home - Granterville, Md.</i>   |  | 24a. REC'D BY REGISTRAR<br>DATE <i>OCT 6 '59</i>  | 24b. REGISTRAR'S SIGNATURE<br><i>Curtis &amp; Thane</i>   |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11226

## CERTIFICATE OF DEATH

Reg. Dist. No.

11208

|  |                                  |  |  |  |   |   |  |
|--|----------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert</b> <b>MARYLAND</b>  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>  |                                  |  |  | c. LENGTH OF STAY IN 1b<br><b>74 years</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Calvert County Hospital</b>   |                                  |  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>George</b>   |                                  | First <b>George</b> Middle <b>W.</b> Last <b>Wood</b>  |  | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>17</b> Year <b>1959</b>  |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 23, 1885</b> |  | 9. AGE (In years last birthday)<br><b>74</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm Owner</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 13. FATHER'S NAME<br><b>John Wesley Wood</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Hance</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>219-36-9284</b>  |  | 17. INFORMANT<br><b>Carroll Wood, St. Leonards, Md.</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br><b>177X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CA of PROSTATE</b><br>DUE TO (c) |                                  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>58</b> , to <b>10/17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/17</b> , 19 <b>59</b> , and that death occurred at <b>3:15</b> M, from the causes and on the date stated above.   |                                  |  |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>R de Villarreal</b> M.D.  |                                  |  |  | ADDRESS (Street, city or town, state)<br><b>St Leonard</b>   |   | DATE SIGNED<br><b>10/17</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>R de VILLARREAL (M.D.)</b>   |                                  |  |  |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Oct 19, 1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Asbury Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Barstow - Calvert Co - Md</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>A. Q. Trakman &amp; Son - Funeral, Inc.</b>   |                                  |  |  | 24a. REC'D BY REGISTRAR<br><b>DATE</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Oct 20 '59</b><br><b>Arthur S. Hance</b>           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11508

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 1, 1900*

5. Date of death: *Dec 1, 1945*

6. Place of death: *New York City*

7. Cause of death: *Heart Disease*

8. Signature of physician: *[Signature]*

9. Signature of registrar: *[Signature]*

10. Date of registration: *Dec 1, 1945*

11. Place of registration: *New York City*

12. Registrar's name: *[Name]*

13. Registrar's address: *[Address]*

14. Registrar's phone: *[Phone]*

15. Registrar's occupation: *[Occupation]*

16. Registrar's signature: *[Signature]*

17. Registrar's date: *[Date]*

18. Registrar's place: *[Place]*

19. Registrar's name: *[Name]*

20. Registrar's address: *[Address]*

21. Registrar's phone: *[Phone]*

22. Registrar's occupation: *[Occupation]*

23. Registrar's signature: *[Signature]*

24. Registrar's date: *[Date]*

25. Registrar's place: *[Place]*

26. Registrar's name: *[Name]*

27. Registrar's address: *[Address]*

28. Registrar's phone: *[Phone]*

29. Registrar's occupation: *[Occupation]*

30. Registrar's signature: *[Signature]*

31. Registrar's date: *[Date]*

32. Registrar's place: *[Place]*

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34. Registrar's address: *[Address]*

35. Registrar's phone: *[Phone]*

36. Registrar's occupation: *[Occupation]*

37. Registrar's signature: *[Signature]*

38. Registrar's date: *[Date]*

39. Registrar's place: *[Place]*

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41. Registrar's address: *[Address]*

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43. Registrar's occupation: *[Occupation]*

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45. Registrar's date: *[Date]*

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